



PROCEDURE FOR TRANSITION OF YOUNG PEOPLE WITH DISABILITIES FROM CHILDREN'S TO ADULTS SERVICES IN MERTON

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1. Introduction

“We want to give all Merton’s young people with disabilities and complex needs the best chance to live fulfilling lives as they move into adulthood.”

Leaving school and moving into adulthood can be a challenging time for all young people and particularly for those with disabilities. It is never too early to think about transition and the aspirations of young people should be at the heart of all planning. Young people and their families and carers may be unsure about what to expect and where to get advice, support or information to help them make decisions at this key time.

This procedure places young people at its centre and it has been developed to support and improve the transition process by ensuring we are all working together for the benefit of young people, their parents and carers. The procedure is based on the new expectations of the Children and Families Act 2014 and the Care Act 2014. It aims to ensure that everyone involved in transition understands the specific roles and responsibilities of the Local Authority, so that practitioners and managers can work together effectively to support the young person.

<p>Our aims for young people are that they are:</p> <p>Able to make decisions and take the lead or are supported by people that can advocate for them</p> <p>Supported to plan what they want to do and achieve</p> <p>Able to enjoy the same opportunities as other young people</p> <p>Able to access appropriate transport services to enable them to use services, participate in social / work activities and to build and maintain social networks</p> <p>Able to try things out beforehand</p> <p>Able to change their mind</p> <p>Supported as close to home as possible via a responsive, person centred local offer</p>	<p>Our aims for young people and their parents/carers are they:</p> <p>Are listened to and fully involved, with consideration given to the principles of the Mental Capacity Act 2005</p> <p>Have one allocated worker within each team to link with</p> <p>Feel supported to achieve their life goals</p> <p>Receive consistent messages and proportionate support</p> <p>Have easy access to understandable and accurate information about the local offer</p> <p>Are supported by agencies that stick with and pursue agreed plans, but are flexible to accommodate change</p> <p>Experience a seamless service that ensures they remain safe as they move in to adulthood when subject to a protection plan</p>
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Transition to adulthood is a time when young people and their families are thinking about their aspirations for the future. If children are likely to have eligible care and

support needs under the Care Act 2014, when they are 18, early joint planning will be needed to maximise the gains that can be achieved before and after transition from Children's Services to Adult Services.

This procedure reflects changes that have come about in respect of the Children and Families Act 2014 and the Care Act 2014 specifically in relation to young people with special educational needs and disabilities. It **does not cover** young carers during transition or adult carers who are caring for someone going through transition.

Together the Children and Families Act 2014 and the Care Act 2014 create a comprehensive legislative framework for transition. They both highlight the need to take an outcome-based approach and promote wellbeing and for the following to take place.

2. Underpinning principles

Drawing on the key messages from the Preparing for Adulthood Programme (Department for Education, 2011); all agencies involved in this procedure need to ensure their practice is in line with following underpinning principles:

Person-centred transition planning

The young person should be at the centre of the transition planning process, giving them choice and control over their own future. This is to ensure the focus is on their needs, hopes and aspirations. Person-centred planning and reviews should support young people, where possible, to express their views, should inform support planning and should ensure positive outcomes for young people.

Involvement and consultation of parents and carers

Young people and their families should be recognised as partners in the process and be actively involved in planning their future. The experience of young people and their families should inform strategic planning and commissioning.

Partnership working across agencies

A shared vision, which places young people and their families at the centre and focuses on improving life chances, should be developed across all partners. Partners must be committed to working together and have a clear understanding of the specific roles and responsibilities of all the key agencies involved in the transition process.

Provision of accessible and clear information

Clear information should be shared with young people to raise aspirations by illustrating what has already worked for others. Information should be developed with young people and their families to ensure it is relevant, accessible and understandable.

Working towards positive outcomes

Transition planning covers every aspect of a young person's life, including education, employment, housing, health, transport and leisure activities. It includes consideration of personal budgets or other forms of allocating resources. Transition planning is focused on life outcomes, promoting independence and supporting young people to lead meaningful and enjoyable adult lives.

Early assessment and transition planning

Starting assessments at age 14 and transition planning facilitates more responsive and flexible forward planning. Timely assessments and transition plans are essential for commissioners to plan services and budgets in advance, for the projected support needs of young people moving into adulthood.

Relevant information sharing

Agencies should share relevant information with each other and with commissioners to ensure the transition process is smooth and that services and opportunities are planned and developed to meet the needs of the young people as they transition to adulthood. Information must be accurate and timely and shared in adherence to data sharing principles.

Quality and monitoring

Accurate monitoring ensures all young people are tracked and none "fall through the net". Mechanisms need to be built in to ensure the quality of provision meets appropriate standards and that the transition process is as effective as possible.

Safeguarding

It is a fundamental principle that disabled children have the same rights as non-disabled children to be protected from harm and abuse. The London Child Protection Procedures and Merton Safeguarding Children procedures and processes must be followed in any instances prior to a young person's 18th birthday. Often disabled children have additional needs related to physical, sensory, cognitive and/or communication requirements and many of the problems they face are caused by negative attitudes, prejudice and unequal access to things necessary for a good quality of life.

For all practitioners and agencies, ensuring young people are safeguarded should therefore always be integral to everything they do. Practitioners should ensure that any young person subject to a protection plan is supported to remain safe as they move in to adulthood.

Safeguarding adults, processes should be considered where necessary when a young person turns 18. In Merton we are guided by the London Multi-agency safeguarding adults policy and procedures that all agencies (including Merton Council) follow. Practitioners in children and families should alert adult social care if they think a safeguarding concern should be raised with full information that is pertinent to the

transition process in relation to risk management and any ongoing protection plans.

3. Governance Arrangements

The Merton Preparation for Adulthood Board exists to adhere to the requirements for governance and strategic leadership to enable effective transition planning that is multidisciplinary in approach. This board has been enacted to support the requirements of the SEND Code of Practice, Children and Families Act 2014 and The Care Act 2014. The Board provides management oversight for the transition functions within education, children's and adults social services, whilst ensuring collaboration with Merton Clinical Commissioning Group (CCG) and other respective community partners with a vested interest in transition.

4. Actions necessary to achieve successful transition

- Planning at 14, particularly for young people with Education, Health and Care Plans where there must be a focus on preparing for adulthood from age 14 (year 9) and young people if they are likely to have needs once they turn 18 regardless of whether they receive support from Children's Services.
- Young people must be involved in discussions and decisions about their individual support and a "strengths based" approach **must** be taken.
- Provision of information and advice to indicate what support young people can expect and what can be done to meet or reduce the needs they are likely to have, as well as what they can do to stay well, and prevent or delay the development of future needs. The focus should be on prevention and early intervention to develop the skills and confidence necessary to achieve clearly identified goals, building the basis for a successful transition to adulthood.
- A transition assessment (Appendix 2) must take place at a time when it will be of "significant benefit" to the young person¹.
- Use approaches that actively promote wellbeing and independence and seek to prevent and or delay the development of care and support needs.
- Improve multi-agency co-ordination/cooperation across education, health, housing and care to promote wellbeing and joint commissioning.
- Young people approaching 18 years of age who appear likely to have care and support needs on turning 18 will require an assessment under the Care Act 2014.

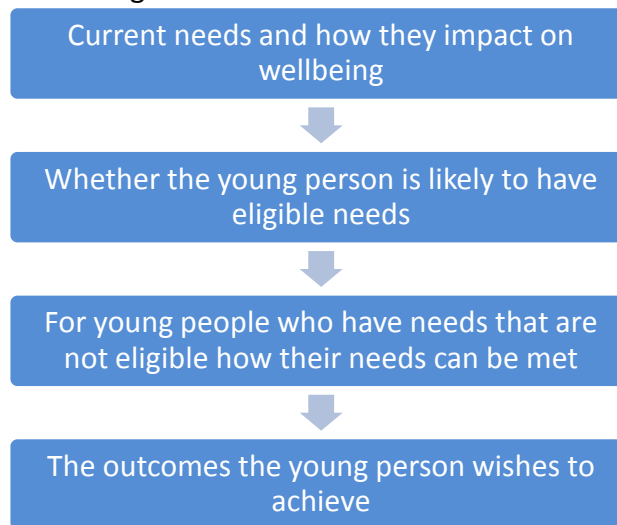
¹'Significant benefit' a transition assessment should occur at a time when doing so is advantageous for the individual young person. This cannot be prescribed and will vary according to wishes and circumstances, but it should be when it is of 'significant benefit' to the individual to do so.

This process is when a person's care and support needs can be assessed by an adult social care practitioner and a support plan be drafted to meet assessed eligible needs. Please see Roles and Responsibilities (Appendix 1) for further detail regarding this process. For those who do not meet Care Act 2014 eligibility following assessment, information and advice can be provided to the young person and their family on voluntary organisations that can assist them.

Transition is a continuous process that enables young people to be better prepared for adulthood. It is not a single event, where a young person is "*transitioned*" from Children's services to Adult social care, but happens over a period of time between the ages of 14 to 25. It offers a young person the best opportunity to fulfill their potential in adulthood.

5. Transition planning and assessments

Both the Children's and Families Act 2014 and Care Act 2014 put a specific emphasis on preparing young people for adulthood and having a transition process that is timely, appropriate and proportionate to the complexity of the young person's needs. The process aims to establish the following:



This procedure is designed to deliver the statutory expectations laid out in both (social care) Acts and it is underpinned by a set of key principles explained in Section 13 below. The Local Authority and key partners has defined responsibilities to ensure:

- a. Young people are supported to plan for the future.
- b. Assessments take place at the right time for the young person and are proportionate to their needs
- c. Channels of communication between departments, teams and professionals are established and build on existing information

- d. Plans are integrated as much as possible to reduce duplication and not repeating assessments that are unnecessary, time consuming and stressful for the young person and their family. This will include pathway plans for “Looked After” young people, the identification of short-term goals as well as medium and longer-term aspirations.
- e. Work is carried out within a reasonable timescale thereby reducing the negative impact of unnecessary delays on the well-being of young people and their families.

6. Procedure

Adults Social Care Transition representatives will meet with Children’s Services colleagues in order to track potential young people who are currently accessing services via Social Care. Adults Social Care Transition representatives will attend requested panels (Post 16 , Tripartite , etc.) in order to gather information and to input into future planning for young people with (potential) adult social care needs.

Referral will be made (in most cases) at 16 for transition work, however in cases where there is significant complexity, the referral for adults’ eligibility consideration may be made earlier. At the point of referral, a transition social worker will be allocated, who will ‘co-work’ the case with their respective children’s colleague, gathering information; meeting with the young person and family and begin the transition assessment process to determine if the young person will meet eligibility for adults social care input.

7. Service user and carer involvement

Young people, parents and other carers need to be made aware of the expected outcomes of the transition pathway and the established process. Young people, parents and other carers have expressed a need to (1) ‘know what is happening’, (2) understand ‘what is possible’ and (3) to be ‘actively involved in making decisions’. They want to ‘know who will do what’, ‘when and how’.

While this procedure is principally written for staff it does answer some of the questions that young people may have. In conjunction with this procedure a transition pathway will be put in place that is compliant with the Care Act 2014 and the Children and Families Act 2014. The aim is that this will provide an easy read and accessible description of what can be expected by all parties involved in the transition process.

Consideration should also be given to the use of Care Act 2014 advocacy where appropriate to help the young person and their family contribute and understand the process of assessments and production of a care and support plan.

8. Safeguarding

Everyone has the right to refuse a transition assessment, however Merton Council must undertake an assessment if it suspects that a young person is experiencing or is at risk of abuse or neglect.

Staff in the Transitions Service carrying out tasks in line with this procedure must remain mindful of their responsibilities to adhere to the London Borough of Merton Safeguarding policies and procedures, which can be found at:
<https://www.scie.org.uk/adults/safeguarding/policies/>

9. Mental Capacity

Young people who have turned 16 years of age are considered to have rights that are applicable under the Mental Capacity Act 2005. There are variations that apply within this context, however for the purposes of this document it is noted that the capacity of those 16+ should be considered when key decisions are to be made. Further, there are implications for Deprivation of Liberties Safeguards (DOLS) which are applied within the context of residential college and other care settings post 18 years and community DOL for non hospital and care settings and safeguarding for 16-17 year olds.. This document clarifies the expectation that the appropriate consideration is to be given to young people who may require support in decision-making, and that appropriate procedures are implemented to evidence and justify this process and best interest decision-making on any young person's behalf.

Timely referral for a Independent Mental Capacity Advocate (IMCA) if necessary following any mental capacity assessment that is undertaken where a significant decision needs to be made and the person is deemed to lack capacity or there is a conflict of interest. The responsibility of making a referral lies with the ASC Transitions.

10. Quality Assurance

This procedure will be regularly monitored and updated to take account of any future changes, particularly in respect of legislation and/ or departmental or cross-departmental policy developments in respect of transition planning. Further adherence to quality assurance will include:

- Review of customer feedback
- Review of complaints and outcomes
- Audits (CSC, ASC, CCG ger. etc.)
- Merton Transition Board
- Review of procedure in 12 months
- Staff training and development
- Tracking processes

It is anticipated that this procedure will be reviewed on an ongoing basis by a newly formed Board operational sub group. This group will include the monitoring of transitions cases and process followed that is highlighted in this document with representatives from Children with disabilities team, ASC transitions, SEND Manager and

CHC team representation. Any changes deemed necessary will be reported to the Board for discussion and approval before the document is formally changed.

	<p>change.</p> <ul style="list-style-type: none"> • CWD or Short Breaks worker and ASC transitions social worker will attend the year 11 or 12 annual review. • Care Leaver status to be added to the social care record. 	X	X
17	<ul style="list-style-type: none"> • CWD or short breaks worker and ASC transitions social worker to arrange joint visit or meeting (earlier for complex cases). At this point, ASC to take responsibility for adult social care element of transition planning, although CWD social worker or short breaks worker will retain casework responsibility. • ASC transitions social worker to complete a Care Act 2014 assessment and Support Plan.. Outcome of any assessment agreed within four weeks from the assessment start date and support plan drafted and ratified through the ASC Outcome Forum, although this timescale may be longer if the young person has complex needs or is in an out of borough setting. If a family state that they do not wish to complete a Care Act 2014 assessment (perhaps not understanding the differences between children's and adult social care or not understanding the consequences of this decision), ASC transitions should consider the use of Care Act advocacy to help the young person and their family understand the process of assessment and drafting of a care and support plan. • ASC transitions to complete a CHC checklist if no CHC funding is in place and the young person has primary health needs. • If CHC funding already in place, CWD should alert the CHC adults team to the young person 3 months prior to turning 18. <p>The completed Care Act 2014 assessment and Support Plan to be ratified by the adult social care Outcomes Forum and required services sourced and implemented by Brokerage Team.</p> <ul style="list-style-type: none"> • Further liaison meetings between CWD SW/ ASC SW and SEN SCO as required. 	X	X
18	Internal recording tasks: Transfer Summary Observation and Transfer/Closure Care assess document completed in Mosaic and reassign to ASC Transitions TM.	X	

Transition Assessment [Adults Social Care Transition Team]

What is the Transition Assessment for?

This assessment is to find out whether you are likely to have eligible needs when you reach 18. This assessment will contribute to your Care Act Assessment when you reach 18. Your assessor will determine (based on the information in this assessment) whether you will likely meet **all** of the following 3 statements:

1. Your needs arise from or are related to a physical disability or learning disability or illness.
2. As a result of your needs you are unable to achieve two or more of the specified outcomes (which are described in this assessment).
3. As a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on your wellbeing.

How to complete the Transition Assessment

Just tick the box that best describes your situation. You may want some help to complete this form. Anyone who knows you well (family member, friend, advocate, care/support worker) can do this—we call this person your supporter. There is a space on the form for you and your supporter to add your view and any supporting information. There is also space for the assessor to put their view and their supporting information.

You can complete this form and return it to us and an assessor will then meet with you (and your supporter) to confirm the information you have given. Or if you prefer, an assessor can meet with you to help you complete the form.

What happens next?

If you have eligible needs, the next step is to complete a care and support plan. This will normally happen when you are around 17 ½, or at time that suits you best. Your care and support plan will start when you reach 18. It will record how you will meet your needs and achieve your outcomes. We will also give you information and advice about other services or organisations that may be able to offer you support.

Once your care and support plan has been completed and agreed, if you are eligible for services, we will inform you of your personal budget. There are different ways that you can manage your personal budget –either by a Direct Payment (via a pre-paid card or Merton managed account), directly provided/ commissioned services, or a mixture of both. If we are arranging support for you, we may need to share information with a service provider.

Financial Assessment

You will also need to fill out a financial assessment form – you will be contacted by the financial assessment team. In many cases the Council will contribute, either fully or partly, to your personal budget. The size of this contribution will be dependent on an assessment of your individual financial circumstances.

Please return to:

1. Personal Details:

SECTION 1

Full name and title:	
Address and postcode:	
Telephone numbers:	Daytime: _____ Mobile: _____
Gender (please tick✓):	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of birth and age:	
Religion:	
GP practice and address:	
National Insurance number:	
NHS number:	
Date of form completion:	

2. Consent

Do you consent to the completion of this assessment?	YES		NO	
Do you agree for this information to be shared as needed with other agencies involved in care?	YES		NO	YES, with limitations
If YES with limitations, please provide details:				

3. Would you describe yourself as: Please tick the box or boxes that best describes you :

✓

Having a sensory impairment?	
Hearing impairment	
Visual impairment	
Other sensory impairment	
Having a long term physical health condition?	
Chronic Obstructive Pulmonary Disease	
Cancer	

	Acquired Physical Disability	
	HIV/AIDS	
	Other	
Having a long term neurological health condition?		
	Stroke	
	Parkinson's	
	Motor Neurone Disease	
	Acquired Brain Injury	
	Other	
Having a learning disability?		
Having Autism? (Excluding High Functioning Autism)		
Having Asperger's Syndrome / High Functioning Autism?		
Having a mental health condition?		
	Anxiety	
	Depression	
	Other	
No relevant long-term Reported Health Conditions		

4. Your employment status

Please tick✓:

1.	Working as a paid employee or self-employed (30 or more hours per week)	
2.	Working as a paid employee or self-employed (16 to less than 30 hours per week)	
3.	Working as a paid employee or self-employed (4 to less than 16 hours per week)	
4.	Working as a paid employee or self-employed (more than 0 to less than 4 hours per week)	
5.	Working regularly as a paid employee or self-employed but less than weekly	
6.	Unpaid voluntary work	
7.	Retired	
8.	Other	

5 Your current housing situation

Please tick✓:

Settled accommodation		
1.	Owner occupier/shared ownership	
2.	Tenant – local authority, registered social landlord, housing association	
3.	Tenant – private landlord	
4.	Living with family/friends (including flat sharing)	
5.	Supported accommodation (supported by staff or resident caretaker)	
6.	Adult Placement Scheme	

7. Approved premises for offenders released from prison or under probation supervision (e.g. probation hostel)	
8. Sheltered Housing/extra Care or other sheltered Housing	
9. Mobile accommodation for Gypsy/Roma and Traveller Community	
Non-settled accommodation	
10. Rough sleeper/squatting	
11. Night shelter/emergency hostel/direct access hostel	
12. Refuge	
13. Temporary accommodation placed by a local authority	
14. Staying with friends/family as a short term guest	
15. Acute/long stay healthcare residential facility or hospital	
16. Registered Residential Care Home	
17. Registered nursing home	
18. Prison/Young Offenders Institution/Detention Centre	
19. Other temporary accommodation	

6. Ethnicity: Please tick one box that best describes your background:

Ethnicity	Please tick	Ethnicity	Please tick
White British		Mixed - White/Black Caribbean	
White Irish		Mixed - other	
White - Other		Arab	
Asian / Brit -Other Asian		Chinese	
Asian / Brit - Pakistani		Gypsy/Roma	
Black / Brit - African		Traveller of Irish Heritage	
Black / Brit - Caribbean		Declined to say	
Black / Brit - Other black		Information not yet obtained	
Mixed - White/Asian		Other ethnic group (please state)	
Mixed - White/ Black African			

7.	Will you have a family member or friend supporting you when you turn 18? If you have answered YES to the above question, they will be offered a carers assessment. This carer's assessment provides an opportunity to explore how your caring role is affecting you and what assistance might be required to support both your ability to continue caring and your own wellbeing.	YES	NO

8.	Would you like a Welfare Benefits Check? If you have answered YES, you can contact Merton Welfare Benefits Team on 020 8545 4178, or we can contact them on your behalf. Please discuss with the social care worker checking this form.	YES	NO

9. Services you currently receive

Please list any services (this could include support from children’s social care, special educational needs, school/colleges and health services) you may currently receive and how often you receive them.

10. Professional Support

Please detail below any professional support you currently receive. (this could be a social worker, community nurse, team support officer, care co-ordinator, occupational therapist, community psychiatric nurse or care manager).

11. Making decisions and organising your life

Please detail below who decides and organises the important things in your life. (If someone has a legal mandate to do so, please record here).

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SECTION 1

1. Maintaining personal care needs

This part combines 3 outcomes about your personal care: **personal hygiene, toileting needs** and **being appropriately clothed**. You need to include information about what you think your needs will look like when you reach 18. You need to include information about all 3 of these areas in order for the assessor to be clear about your needs and desired outcomes. You have to meet at least 2 of these areas in order to be eligible in this outcome.

Please include information about:

- The support/encouragement you need to look after yourself and your personal appearance and hygiene.
- Your ability to access and use the toilet and manage your toilet needs
- Being able to dress yourself and to be appropriately dressed, for instance in relation to the weather to maintain your health.

Desired Outcome: I am able to meet my personal care needs, including being able to manage my toilet needs, personal hygiene and being appropriately clothed.

Ability to achieve outcome: please choose one option from the list below:

Please tick

- | | |
|--|--|
| 1. I am able to achieve without assistance or significant impact on wellbeing | |
| 2. I am able to achieve the outcome without assistance but doing so causes or is likely to cause significant pain, distress or anxiety | |
| 3. I am able to achieve the outcome without assistance but doing so endangers or is likely to endanger the health and safety of myself or others | |
| 4. I am able to achieve the outcome without assistance, but takes significantly longer than would normally be expected. | |

5. I am unable to achieve without assistance		
Summary of need and desired outcome		
Customer/Supporter view(why and what help is needed with personal hygiene, toileting and being appropriately clothed):		
Assessor view (including risks and details of fluctuating needs):		
Is there, or likely to be a significant impact on your wellbeing?	YES	NO

2. Managing and maintaining nutrition

This section is about whether you are able to manage and maintain your nutrition and whether you are able to prepare and consume food and drink. You need to include information about what you think your needs will look like when you reach 18.

Desired Outcome: I am able to manage and maintain my nutritional needs	
Ability to achieve outcome: please choose one option from the list below:	Please tick
1. I am able to achieve without assistance or significant impact on my wellbeing	
2. I am able to achieve the outcome without assistance but doing so causes or is likely to cause significant pain, distress or anxiety	
3. I am able to achieve the outcome without assistance but doing so endangers or is likely to endanger the health and safety of myself or others	

4. I am able to achieve the outcome without assistance, but takes significantly longer than would normally be expected.	
5. I am unable to achieve the outcome without assistance	

Summary of need and desired outcome

Customer/Supporter view(why and what help is needed):

Assessor view (including risks and details of fluctuating needs):

Is there, or likely to be a significant impact on your wellbeing?	YES		NO	
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3. Being able to make use of the home safely

This part is about you being able to move around your home safely, which could include getting up stairs, using kitchen facilities or accessing the bathroom. This also includes having access to your property, for example having steps leading up to your home. You need to include information about what you think your needs will look like when you reach 18.

Desired outcome: I am able to move around the home and access my home safely	
Ability to achieve outcome: please choose one option from the list below:	Please tick
1. I am able to achieve without assistance or significant impact on my wellbeing	
2. I am able to achieve the outcome without assistance but doing so causes or is likely to cause significant pain, distress or anxiety	
3. I am able to achieve the outcome without assistance but doing so endangers or is likely to endanger the health and safety of myself or others	
4. I am able to achieve the outcome without assistance, but takes significantly longer than would normally be expected.	
5. I am unable to achieve the outcome without assistance	
Summary of need and desired outcome	
Customer/Supporter view(why and what help is needed):	
Assessor view (including risks and details of fluctuating needs):	

Is there, or likely to be a significant impact on your wellbeing?	YES		NO	
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4. Maintaining a habitable home environment

This part is about the support you need to keep your house sufficiently clean and maintained to be safe. Please include information about how you manage day-to-day tasks e.g. housework, shopping, gardening, routine maintenance, paying bills and managing your money. A habitable home is safe and has essential amenities such as water, electricity and gas. You need to include information about what you think your needs will look like when you reach 18.

Desired outcome: I am able to maintain a habitable home environment to be sufficiently clean and safe	
Ability to achieve outcome: please choose one option from the list below:	Please tick
1. I am able to achieve without assistance or significant impact on my wellbeing	
2. I am able to achieve the outcome without assistance but doing so causes or is likely to cause significant pain, distress or anxiety	
3. I am able to achieve the outcome without assistance but doing so endangers or is likely to endanger the health and safety of myself or others	
4. I am able to achieve the outcome without assistance, but takes significantly longer than would normally be expected.	
5. I am unable to achieve the outcome without assistance	
Summary of need and desired outcome	
Customer/Supporter view(why and what help is needed):	
Assessor view (including risks and details of fluctuating needs):	

Is there, or likely to be a significant impact on your wellbeing?	YES		NO

5. Developing and maintaining family or other personal relationships

This part is about whether you feel lonely or isolated, either because your needs prevent you from maintaining the personal relationships you have or because your needs prevent you from developing new relationships. You need to include information about what you think your needs will look like when you reach 18.

Desired Outcome: I am able to maintain family and other personal relationships and I do not feel lonely or isolated	
Ability to achieve outcome: please choose one option from the list below:	Please tick
1. I am able to achieve without assistance or significant impact on my wellbeing	
2. I am able to achieve the outcome without assistance but doing so causes or is likely to cause significant pain, distress or anxiety	
3. I am able to achieve the outcome without assistance but doing so endangers or is likely to endanger the health and safety of myself or others	
4. I am able to achieve the outcome without assistance, but takes significantly longer than would normally be expected.	
5. I am unable to achieve the outcome without assistance	
Summary of need and desired outcome	
Customer/Supporter view(why and what help is needed):	
Assessor view (including risks and details of fluctuating needs):	

Is there, or likely to be a significant impact on your wellbeing?	YES		NO	

6. Making use of necessary facilities or services in the local community including public transport and recreational facilities or services

This part is about your ability to get around in the community safely and your ability to use public transport, shops, places of worship or recreational facilities. You need to include information about what you think your needs will look like when you reach 18.

Desired Outcome: I can make use of necessary facilities or services in the local community including public transport and recreational facilities or services	
Ability to achieve outcome: please choose one option from the list below:	Please tick
1. I am able to achieve without assistance or significant impact on my wellbeing	
2. I am able to achieve the outcome without assistance but doing so causes or is likely to cause significant pain, distress or anxiety	
3. I am able to achieve the outcome without assistance but doing so endangers or is likely to endanger the health and safety of myself or others	
4. I am able to achieve the outcome without assistance, but takes significantly longer than would normally be expected.	
5. I am unable to achieve the outcome without assistance	
Summary of need and desired outcome	
Customer/Supporter view(why and what help is needed):	

Assessor view (including risks and details of fluctuating needs):

Is there, or likely to be a significant impact on your wellbeing?	YES		NO	
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7. Accessing and engaging in work, training, education or volunteering

This part is about whether you have the opportunity to contribute to society through work, training, education or volunteering subject to your wishes. This includes physical access to any facility and support with the participation in the relevant activity. You need to include information about what you think your needs will look like when you reach 18.

Desired Outcome: I can access and engage in work, training, education or volunteering as much as I want to	
Ability to achieve outcome: please choose one option from the list below:	Please tick
1. I am able to achieve without assistance or significant impact on my wellbeing	
2. I am able to achieve the outcome without assistance but doing so causes or is likely to cause significant pain, distress or anxiety	
3. I am able to achieve the outcome without assistance but doing so endangers or is likely to endanger the health and safety of myself or others	
4. I am able to achieve the outcome without assistance, but takes significantly longer than would normally be expected.	
5. I am unable to achieve the outcome without assistance	

Summary of need and desired outcome

Customer/Supporter view(why and what help is needed):

Assessor view (including risks and details of fluctuating needs):

Is there, or likely to be a significant impact on your wellbeing?	YES		NO	
---	------------	--	-----------	--

8.Caring Responsibilities

This part is about any caring or parenting responsibilities you have for a child and support you may need with this. You need to include information about what you think your needs will look like when you reach 18. If you have no caring responsibilities, please tick outcome number 1.

Desired Outcome: I am able to play my full role as a parent or Carer	
Ability to achieve outcome: please choose one option from the list below:	Please tick
1. I am able to achieve without assistance or significant impact on my wellbeing	
2. I am able to achieve the outcome without assistance but doing so causes or is likely to cause significant pain, distress or anxiety	
3. I am able to achieve the outcome without assistance but doing so endangers or is likely to endanger the health and safety of myself or others	
4. I am able to achieve the outcome without assistance, but takes significantly longer than would normally be expected.	
5. I am unable to achieve the outcome without assistance	

Summary of need and desired outcome

Customer/Supporter view(why and what help is needed):

Assessor view (including risks and details of fluctuating needs):

Is there, or likely to be a significant impact on your wellbeing?

YES

NO

Transition Plan

Detailed below is a copy of your transition plan. This records how your eligible needs will be met and your outcomes achieved. Throughout this planning process, we can also give you information and advice about other services or organisations that may be able to offer you support.

My key outcomes:

--

Which needs will be met by family and friends

--

Which needs will be met by Education
Which needs will be met by Health
Which needs will be met by my Community (voluntary, faith, community organisations)
Which needs will be met by Merton Adult Social Care

My action plan

Authorisation

If you are happy with how this assessment has been completed, and willing to give your permission for the person who is checking this form to contact any person or agency they feel is necessary or undertake essential activity in order to meet your assessed care needs, please sign below.

Signature:

Name (print):

Date:

If you are willing to give your permission for the person who is checking this form to contact some people or agencies BUT not others, please indicate those **we may not** contact and sign below.

Please do NOT contact the following people or agencies

Signature:

Name (print)

Date:

OR

I believe that the individual appears to lack the capacity to give informed consent.

Signed:

Position:

Name:

Date:

OR

The individual is unable to sign and I have authority to give consent on their behalf.

Signed:

Date:

Name:

Position:

Witnessed:

Date:

INFORMATION FOR ALL

Please note that some information may be shared with or without your permission. This includes information on criminal activity, matters of child protection, information related to public safety and to your own safety in certain circumstances. In these situations, we may share information with medical practitioners, housing officers, the police or probation services. We will inform you of our intention to share information whenever we can.

You are welcome to request access to your records (both written and electronic) under the terms of the Data Protection Act 1998 and Merton Council's Access to Client Records policy.

Declaration by Assessor

- I have checked this Transition Assessment

Name

Signature

Date

Job title/team

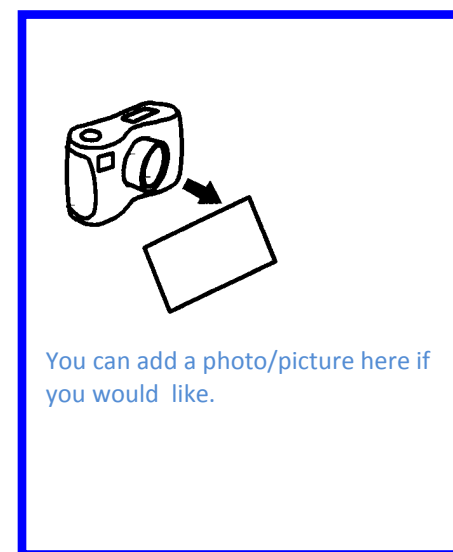
Service

Contact telephone and e-mail

Merton Transition Plan

All About Me

Name:	
Address:	
Telephone number:	
Birth date:	
School:	
Ethnicity:	
Gender:	
First Language:	
Parents/Primary Carers name Address & contact number if different from above	
Other family members/friends	
Children's Social Worker	
Adult Social Worker	
Class teacher/Tutor/key worker	
LDD/SEN Personal Adviser	
GP	
Shortbreaks Co-ordinator	



All about me: Where I live and who I live with People who are important to me (my family, friends, at school, other people) To be successful in supporting me and communicating with me Things people like about me What I am good at and what I enjoy doing (at home, at school and out and about) What I need to stay healthy What I need to stay safe	Pages 4-5
What I can do and the help and support I need What can I do for myself The help and support I need Getting out and about and using transport etc. Reading, writing, counting and managing my money etc. Making friends and getting along with people My cultural and religious needs	Pages 6-7
My hopes and dreams for the future Learning (School, College, Adult Education) Work/Employment What would I like to do? Where and Who I would like to live with in the future Any Other Hopes and Dreams for the Future	Page 8
My Step-Up action plan	Page 9
Health & Well-being	Page 10
The Team Around Me	Page 12
Parents/Carers views	Page 13
My Step-Up review	Page 14

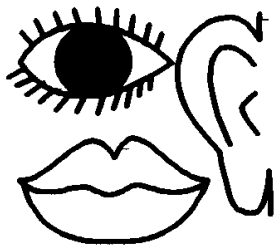
All about me



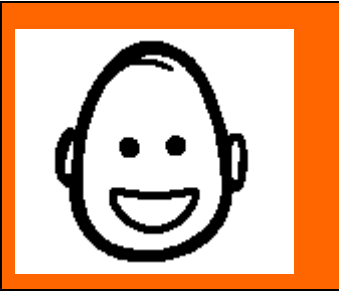
Where I live and who I live with:



People who are important to me (my family, friends, at school, other people):



To be successful in supporting me and communicating with me, you need to:



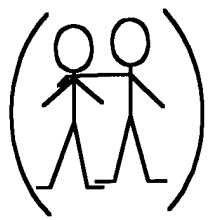
Things people like about me:



My religious and cultural needs:



What I am good at and what I enjoy doing (at home, at school and out and about):

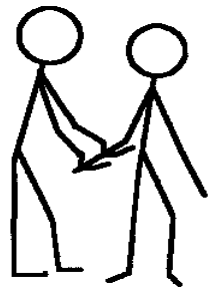


To stay healthy and safe I need to:

.

What I can do and the help and support that I need

This part is about washing, dressing, cleaning my teeth, brushing my hair, choosing my clothes, bathing, showering, going to the toilet, eating, drinking, shaving, help with transferring, getting in and out of bed, looking after my personal hygiene etc.



Washing, dressing, cleaning my teeth, brushing my hair, choosing my clothes, bathing, showering, going to the toilet, eating, drinking, shaving, help with transferring, getting in and out of bed, looking after my personal hygiene, preparing off etc.

|



Getting out and about and using transport etc:



Reading, writing, counting and managing my money etc:



Making friends and getting along with people:

My hopes and dreams for the future



Learning (School, College, Adult Education)



Work/Employment What would I like to do?



Where I would like to live with in the future:





Who I would like to live with:



Any Other Hopes and Dreams for the Future

My Step-Up action plan

Date:

Key Hopes and Dreams about the future	What I want to do	How can we make it happen?	Who will take responsibility & who will be involved?	By when?
 <p>My Learning (school, college, Adult Education)</p>				
 <p>How I will support myself in the future (work, employment)</p>				
 <p>Where I want to live</p>				
 <p>Any other hopes and dreams</p>				

Health & Well-Being

Transition Health Profile: This section of the Step-Up Plan, should be completed with the help of the school nurse, GP, specialist health professional (i.e. paediatrician, hospital consultant, nurse specialist, occupational therapist psychiatrists etc) parents/carers &/or significant other.

Nature of Disability

Medical services, therapies & interventions used (include names and contact details of known individuals).

Medical issues (i.e. pain, continence, sleeping, mobility, weight, allergies, etc)

Medication (what it is prescribed for, how often, if the young person is self medicating, known side effects)

Mental Health (are there any concerns related to depression, anxiety, self-harm etc)

Behaviour (are there any behaviours which cause concern or prevent the person from participating in activities)

Does the young person use any specialist equipment, who provides this equipment and how often is it reviewed?

How will this young person access this equipment once they leave school move to adult health care?

What are the plans for this young person's transition to adult health services?

Parents/Carers' views

Key Hopes and Dreams about the future of my son/daughter

Learning (School, college, university, Adult Education, work-based training)

How my son, daughter will support themselves in the future (training, work, employment)




Where and how he/she will live (independent life skills).


Any other hopes and dreams

The Team Around Me

My Step-Up plan review

Date:

Key hopes and dreams about:	What has happened?	What needs to happen now – what actions do we take or do we need to change the plan?	Who will take responsibility, others involved	When will this happen?
 <p>My Learning (school, college, work-based training)</p>				
 <p>How I will support myself in the future (work, employment)</p>				
 <p>Where I want to live</p>				

 <p>Any other hopes and dreams</p>				

Name:

Job Title:

Contact No: